

# The Hunters Point-Bayview Community Health Service

*(A Project of the John Hale Medical Society, the San Francisco Chapter of the National Medical Association)*

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IN THE EARLY part of 1967 a group of neighborhood people spearheaded by the author felt that a new and innovative approach was needed to improve the delivery of health care in a community in which, for one reason or another, health care was not widely enough available or well enough used. The community involved, known as the Hunters Point-Bayview district of San Francisco, contains several hard-core areas of low income and other disadvantages, such as are typically found in most metropolitan areas today.

The area to be served by the effort to improve health care covers five census tracts and contains approximately 55,000 people. Of this number, approximately three-fifths are white. The sections in greatest need in the area comprise public housing occupied by about 15,000 persons, 90 percent of whom are black.

In trying to create a new approach, the group was aware of the writings of Professor Anselm Strauss of the University of California Medical Center. In a paper written for the Institute for Policy Studies, Washington, D.C., entitled "Medical Organization, Medical Care and Low-Income Groups," Dr. Strauss questioned whether low-income Americans would realistically expect anything like equality of care without considerably more far-reaching reforms in our present system of medical and health care delivery than are instituted by present legislation or assumed in current

planning. His argument was that it is erroneous to assume that the system of medical organization is basically sound, and that medically disadvantaged groups can be reached without radical transformation of this system. He further said that, with that error at its base, the further assumption that more financial support, manpower, and various other kinds of resources are needed must also fail. These resources, he noted, "are used principally for improved efficiency of the present system but do not alter or modify the delivery of services to these groups." Moreover, Dr. Strauss said, "the placing of centers in the low-income locale [is not] the solution, since a study has shown that this does not in itself draw sufficiently upon the population to make 'much of a dent' on low-income illnesses."

After several community meetings, the consensus of the group was that delivery of health care to the poor would never be effectively improved unless changes could be brought about in the life style of the poor, particularly with regard to their attitude and behavior toward health care. As most physicians know, the poor generally delay seeking health care until it becomes an emergency. In other words, they are crises-oriented. Such delay may be due in part to ignorance or poor health habits, but frequently it is due to social, cultural and economic obstacles beyond their control. A missed appointment may not be the result of indifference, but quite often due to lack of transportation, to baby-sitting problems, or even to lack of car-fare money to and from the physician.

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The community group also felt that a double standard of health care should be eliminated. The clinic approach, regardless of how it may be "dressed up" in the new programs which are being set up throughout the country, has never met the real needs of the poor, especially the black poor. As an illustration, deaths per 1,000 from cancer of the cervix in white women from 1940 to 1963 dropped from 22 to 16. In black women during this period, it did not significantly change—30 to 29. The feeling of the community group was that Title XIX of Public Law 89-97 (the amended Social Security Act of 1935) should be strongly implemented by allowing the poor to have freedom of choice and directing them, as much as is feasible, into the private sector of health care. Just as a dual system of education is inherently unequal and morally wrong, so is a double standard of health care. The group concluded that four steps were mandatory; we must

1. Provide freedom of choice of physicians or health facilities, as much as is feasible.
2. Make maximum use of existing facilities, preferably private when feasible.
3. Affect the life style of the poor as it relates to health.
4. Bring some impact upon the providers of health services to change their attitude toward the poor.

The method to achieve the foregoing entails establishing four health teams. Each team will consist of a public health nurse, a social worker, a secretary and six social health technicians. The latter are community non-professional people who are to be given a 26- to 30-week training period while on the job. They are called social health technicians because they will deal with the social problems of the family or individuals with the ultimate goal of improving the family's or the individual's health.

The teams will spend 80 to 90 percent of their time in the field. Contact with cases will be made by "cold canvass" (knocking on doors) and by referrals from other agencies, neighbors or the client-patient. Great emphasis will be placed on follow-up. It is not enough to tell the poor where to go for help for they frequently get lost in or become frustrated by bureaucracy. Hence, where indicated, they will be accompanied to the hospital, to a physician's office or to whatever agency can be useful in a given situation.

In specific cases where follow-up appointments

are in order and the patient has been known to be a chronic "appointment misser," a team member will try to develop the rapport and intimacy of contact so that he or she can call on the patient to encourage or persuade him to keep his appointments for his own good. However, we will constantly keep in mind that we are not to make people dependent upon us. The focus, thus, in helping will be to develop self-help by the client-patient. Our goal will be to assist him only to give him the confidence he needs to build self-reliance.

A research-evaluation component has been built into the program. The research department is headed by a social scientist. At present, several studies are in the active stages.

1. To determine the community's attitudes toward health.

2. To determine the power structure in the community. Once the key people have been identified, then we can establish a relationship with them to assist us in developing new policies for the program.

3. To determine the lines of communication in the community. Once known, then it becomes simple for us to tap in and feed information about the program to the community as well as receive information.

4. Multiphasic screening through the San Francisco Kaiser Hospital will be done on 200 heads-of-household and 50 children in the area (chosen through a random sample process) to establish a baseline of what the disease process of the community is at this time. Funds are not available for a larger sample, but the project will be open-ended.

5. As an extension of the first four stages, we are seeking funds so that the information obtained from the studies can be distributed for consumption by the community in language or through media understood by them. One of the reasons low-income groups resent research on them is that they never hear about the results and never see any direct benefits—their life situation does not change. To put it bluntly, they feel exploited, and understandably so. The researcher, for his study of the ghettos, gains recognition and honors from his peers; the researched person in the ghettos remains jobless, homeless and in despair.

By giving the community the results of our studies, we hope to provide it with a concrete tool of specifics to help in plotting a course toward improving the health of the community.

In November 1967 the John Hale Medical Society, the San Francisco Chapter of the National Medical Association, submitted to the United States Public Health Service a proposal for a five-year project to be funded under Public Law 89-749 (Comprehensive Health Planning). A grant of \$705,046 was awarded for the first year's budget starting 1 July 1968. Six months from the funding date, the program had been administratively organized, all of the staff had been hired with the exception of two of the teams (which will have been staffed by the time this appears), office space has been secured and utilized (there has been no

need to build an elaborate clinic facility since direct medical services are not given), and over 100 cases have been assisted. This type of project points out the speed with which the program can get started and time is of the essence these days.

I would repeat that the mere establishment of a physical plant will not greatly alter the behavior of large masses of poor people—a shining example of this is public housing. We must give direct attention to the low-income consumer and affect his life style directly in our future planning for improving health care delivery to this group. Freedom of choice should be maintained at any cost.

### DIAGNOSTIC PEARLS FOR THREE NEW PEDIATRIC SYNDROMES

"One should be aware of the syndrome of Bassen-Kornzweig (or a beta lipoproteinemia) in an infant or child who has . . . large foul-smelling stools, who fails to thrive, whose sweat chloride levels are normal, and who does not have recurrent pulmonary infections. The pearl I would suggest is to look at the peripheral blood smear and look for the very peculiar-looking red cells which are rather pathognomonic of this entity. This is a malabsorption syndrome, far less common than cystic fibrosis and celiac syndrome, but does occur and has been reported much more frequently in the last few years.

"One might think of the Toulouse-Lautrec syndrome (pyknodysostosis) when one sees a child who has frequent fractures, whose x-rays show increased brittleness or density of the bones, whose cranial sutures fail to close, whose hands are deformed, and whose chin recedes. All children who are short and squat are not achondroplastic; some may well have this syndrome of Henri de la Toulouse-Lautrec.

"The third syndrome, fatal granulomatous disease of childhood, can be picked up; but this requires certain complicated laboratory tests to determine the phagocytic activity of the neutrophils. There are no real pearls for the practitioner in his office without the help of a good hematologic laboratory. However, most of the patients are males, and most of them have chronic suppurative lymphadenitis; and I think knowing this should alert one to the possibility of this particular syndrome."

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